December 18, 2000

Dr. Stuart Altman and Justice Herbert Wilkins
Chairmen, Health Care Task Force
The Executive Offices of Human Services
One Ashburton Place
Boston, MA 02108

Dear Dr. Altman and Justice Wilkins:

Health Care For All, the state's largest health care consumer advocacy group, would like to thank the Health Care Task Force and the working group on health care access for the discussion on access to insurance, and to take this opportunity to comment on the preliminary report. We continue to believe that universal coverage is both desirable and achievable. But since universal coverage is not the focus of this report, and there will be a separate commission set up under Chapter 141 to address this issue, we are writing to respond to the range of incremental options that was presented by the working group.

Our success in Massachusetts with the coverage of children demonstrates that we can greatly improve access to care through incremental reform. Currently we have achieved a 97% coverage rate for children, with very little crowd-out through a combination of public insurance for those who lack coverage, and premium subsidy programs. However, when we turn our attention to adults, it is obvious that we still have great room for improvement. In particular, working adults who lack access to employer-sponsored coverage have to date been largely ignored in our efforts to expand coverage. According to the Department of Health Care Finance and Policy (DHCPF), 68% of employed uninsured are ineligible for coverage (DHCFP, Aug 2000). Without a doubt, the percentage for low-wage workers is far higher.

The working group suggested a variety of possible incremental approaches to addressing the problem of the uninsured. We endorse several of these approaches, particularly those that build on our current successes. At the same time, we are extremely skeptical of the approaches that seek to expand coverage by shifting significant costs to individuals since such approaches almost invariably disadvantage poorer and sicker residents. Many of these approaches were previously tried in Massachusetts and elsewhere, and they were unsuccessful.

Here are our specific comments on the options articulated by the working group:

Public Options

The elimination of categorical requirements that was called "radical" by the working group is an approach that we believe will move us forward. As noted above, it is the non-categorical adults who constitute the bulk of the remaining uninsured. Broadening eligibility to public coverage has worked extremely well for children without crowd-out, and can work for adults as well.

Regarding the short-term unemployed, we observed they are generally already eligible for the Medical Security Plan (MSP). We have been strong advocates of better coordination between the MSP and MassHealth for a long time, which speaks to the recommendation of the working group about streamlining state programs. There should be some recognition that as MassHealth expands, the number of people who will turn to the MSP declines, and so it may be appropriate to use some portion of MSP funds to support current or future MassHealth expansions.

Insurance Reform

In our view insurance product redesign and insurance market reform should be approached with extreme caution because it is likely to have an adverse effect on poorer and sicker residents. Prior to reform, small employers, and individuals who had high utilization rates, were priced out, or refused entry to the market.

Broadening rate bands is at best a zero sum game unless a sufficient number of healthier enrollees can be brought into the market to offset premium increases for sicker populations. Income-based, premium subsidies are a more reliable and equitable avenue to lowering the price of insurance for those who are unable to afford a community-rated policy. (Broadening rate bands would also complicate the administration of any subsidy program since the adequacy of the subsidy would depend not only on income, but on the risk profile of an individual or group)

Past experience with "bare bones" plans both in Massachusetts and elsewhere has shown that interest is generally weak. It encourages the sale of high-deductible plans, meaning that less shared risk and more risk of illness is placed on the back on the individual. For a low-income individual, the likely outcome is not as much use of preventive and ambulatory care, and more preventable hospitalizations. High-deductible plans, if coupled with income-based subsidies, would the have the effect of transferring costs now borne by the private sector to the public sector. We do not view this as a necessarily bad outcome as long as there is the necessary commitment to fund the public contribution.

Medical Savings Accounts and flexible spending accounts are simply specific and extreme examples of redesigning insurance, as they tend to undermine the risk pooling that takes place in the current system. We believe they move us in the wrong direction.

(See, for example, Karen Davis, MMS, October 2000 for discussion of benefits of maintaining employer system.)

We were surprised there was not a mention of pooled purchasing as a strategy for keeping insurance more affordable. If properly constructed, such pools could have the advantage of enhancing consumer choice.

As a final note on insurance reform, we wish to remind the Task Force members, it is important not to judge the success of our nongroup reforms by the size of the nongroup market. An explicit goal of the reform was to shrink the size of that market by making more people eligible for group coverage.

Subsidies and Mandates

With regard to subsidies to purchase insurance we believe this can be an effective strategy when complemented by the availability of public insurance for those who do not have an employment-based option. As a stand-alone approach, it leaves too many people behind.

The working group asserts that "pay or play" proposals are pre-empted by ERISA. The extent to which it is so remains an open question, but as we consider pay or play to be beyond the scope of incremental reform; we will not comment further at this time except to say that it may be a necessary component of a universal system.

Any discussion of individual mandates should be deferred until after a full range of subsidy programs is in place, and their efficacy and limitations can be evaluated. Any proposal for an individual mandate that does not fully address affordability would be a regressive step that might force people to sacrifice other necessities such as food or housing in order to procure health care.

Finally, we embrace the notion of an indirect mandate. It is at least ironic, that as the Commonwealth seeks to promote coverage in the private sector, so many workers who provide services, largely funded by the state, are themselves uninsured. This is particularly unconscionable as many of these workers are themselves engaged in the provision of health care (e.g. personal care attendants and home health aides). There could be a variety of approaches to remedying this problem. One would be to require contractors to offer a base level of health insurance. However, any such initiative must be accompanied by a review of the adequacy of the rates the Commonwealth pays. The benefit of this approach is that, in addition to directly extending coverage to many who are currently uninsured, it would likely encourage other employers of low-wage workers to offer health benefits as well.

In conclusion, while favoring comprehensive, universal coverage, we at Health Care For All recognize that debate on this issue will necessarily be lengthy. In the interim,

there are immediate incremental steps that can and should be taken to expand access to insurance. While pursuing these steps, we should avoid initiatives that shift significant risk onto individuals.

We believe the Commonwealth's approach to health insurance for children is a successful model that can be replicated for many of the remaining uninsured. Components of this model include insurance subsidies for those who have employer coverage available, and public coverage for those who do not. Furthermore, as is the case for children, benefits should be comprehensive at the lower end of the income scale, but more limited and available on a sliding scale for higher income groups to discourage abandonment of existing private insurance. Since a significant catastrophic safety net, in the form of the Uncompensated Care Pool already exists, the focus of limited benefits should be primary and preventive care (again as is the case with our children's program) to encourage appropriate utilization, and to avoid preventable hospitalizations.

As we have successful models already in place to build upon, a lengthy study of approaches is not required. Instead we are calling for the political commitment to allocate sufficient resources for needed programs. With the support of many of the Task Force members, we recently filed legislation that moves us in that direction. We would welcome the support of all Task Force members in moving this critical issue forward.

Sincerely,

Robert Restuccia
Executive Director